WYNNE SHAW, LPC-S

CHILD CLIENT INFORMATION

Name of child _____

Sex____ DOB ____/____/____ School _____ Grade_____

Child's Social Security # _____-_____-_____

Parent(s) Name: _____ Marital status _____

Address _____

City_____ State_____ Zip _____

Contact #: Cell ( )_____-_____ Work ( )_____-_____

Which contact # do you prefer? _____ Can I leave a message at that number? _____

Are there any custody orders in place regarding this child?_____

By law I cannot begin therapy with a child until I have a copy of custody orders.

INSURANCE INFORMATION:

I do not accept reimbursement from insurance but if you would like me to file your claim with your insurance company, please provide the following information.

Name of Primary Insured_____

Primary Insured DOB____/____/____ Primary Insured SS# _____-_____-_____

Relationship to child_____

Primary Insured Employer_____

Employer's Address_____

Insurance Company _____

Address:_____

Phone:_____

Policy/Id #_____ Group # _____

WYNNE SHAW, LPC-S

ADULT CLIENT INFORMATION

Client Name _____ DOB ____/____/____

Sex_____ Client's Social Security # _____-_____-_____ Marital status _____

Address _____

City_____ State_____ Zip _____

Contact #: Cell ( )_____-_____ Work ( )_____-_____

Which contact # do you prefer? _____ Can I leave a message at that number? _____

INSURANCE INFORMATION:

I do not accept reimbursement from insurance but if you would like me to file your claim with your insurance company, please provide the following information.

Name of Primary Insured_____

Primary Insured DOB____/____/____ Primary Insured SS# _____-_____-_____

Relationship to client_____

Primary Insured Employer_____

Employer's Address_____

Insurance Company _____

Address:_____

Phone:_____

Policy/Id #_____ Group # _____

KIM HUMPHRIES & ASSOCIATES, LLC

HEALTH INFORMATION RIGHTS

Although your records are the physical property of **Kim Humphries and Associates, LLC** the information belongs to you. You have the following rights with respect to your information, which you can exercise by presenting a written request to this office.

You have:

• The right to request restrictions on certain uses and disclosures of your information. However, we are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. *For example* – a request that we not identify the agency when we contact you. (i.e. "This is **Kim Humphries and Associates** calling.")

• The right to inspect and copy the information we maintain about you. However, we ***may deny an individual access***, provided the individual is given the right to have such denials reviewed, in the following circumstances:

• A health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to ***endanger the life or physical safety of the individual or another person***.

• The information makes ***reference to another person*** (unless the other person is a health care provider) and the health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person.

• The request for access is made by the individual's personal representative and the health care provider has determined, in the exercise of professional judgment, that the provision of access to such personal representatives is reasonably likely to cause substantial harm to the individual or another person.

• If you wish to inspect or copy your information, you must submit your request in writing to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

• The right to billing records.

• The right to revoke your consent to release information except to the extent that the agency has taken actions in reliance on the previously signed consent form.

• The right to reasonable requests to receive confidential communications of protected health information from us by alternate means. For example, at your regularly scheduled appointment, by email, or by fax.

• The right to amend your information if you feel it is incomplete or inaccurate. You must make this request in writing to your therapist stating exactly what information is incomplete or inaccurate and your reasoning to support your request. We will respond to your request within 60 days. In rare cases your request may be denied.

• The right to receive an accounting of disclosures of protected health information.

• The right to obtain a paper copy of this notice from us upon request.

• The right to file a complaint if you believe we have violated your medical information privacy rights.

You have the right to file a written complaint to **Kim Humphries and Associates, LLC** or directly to the Secretary of Health and Human Services.

To file a complaint with our practice you may contact the following licensing boards:

We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. If and when one is available, you may request a written copy of a revised notice from this office.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave. S.W.
Washington, D.C. 20201
877.696.6775

_____ _____

Signature of Client/Responsible Party Date

KIM HUMPHRIES & ASSOCIATES, LLC

Texas Board of Social Work Examiners
1100 West 49th Street
Austin, Texas 78756-3183
(512) 719-3521

Texas State Board of Examiners of Professional Counselors
1100 West 49th Street
Austin, Texas 78756-3183
(512) 719-3521

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
We are required by The Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by **Kim Humphries and Associates**, **LLC** and of your individual rights and **Kim Humphries and Associates'** legal duties with respect to confidential information.

Ways in Which We May Use and Disclose Your Protected Health Information
We may use and disclose at our discretion your medical records for each of the following purposes only: treatment, payment, and health care operations.

• **Treatment** means providing, coordinating, or managing mental heath care and related services. *For example* – use or disclosure by the health care provider in training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.

• **Payment** means activities such as obtaining payment for the mental health care services we provide for you either from your insurance or another third party payer. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, and procedures performed.

• **Health care operations** include the business aspects of running our practice. *For example* – to evaluate our treatment and services, or to evaluate our staff's performance while caring for you.

We may contact you to provide appointment reminders or other services that may be of interest to you.

We will disclose your protected heath information to any person *you identify* that is involved in your care or payment for your care. *For example* – a family member, relative, close friend, pastor, or pastor's representative with whom you have asked us to communicate.

We will use and disclose your protected health information *when required by federal, state, or local law*. There are certain situations in which as a therapist I am required by ethical standards to reveal information obtained during therapy to other persons or agencies – even if you do not give permission.

These situations are as follows:
(a) If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies;
(b) if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare or social agency which may then investigate the matter;
(c) if I am required by a court of law (court order) to turn over records to the court or if I am ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked.
You may revoke an authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Please sign to indicate you understand our operational use of your information for treatment, payment, and health care operations as stated above.

_____ _____

Signature of Client/Responsible Party Date

KIM HUMPHRIES & ASSOCIATES, LLC
600 West Campbell Road, Suite One Richardson, TX 75080